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N 000	Initial Comments On 06/13/2023, with information obtained through 06/20/2023, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation and standard licensing survey at Homestead Living Inc, a community-based residential facility (CBRF) located in Waunakee, WI. As a result of the survey, 5 deficiencies were identified. One deficiency was a repeat deficiency from Statement of Deficiency (SOD) LJFI11, dated 07/26/2021. The complaint was substantiated. Census: 12	N 000		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the	N 230		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 230	Continued From page 1 provider did not ensure that 2 of 2 employees reviewed were provided with orientation training in all the required topics before performing job duties. Caregiver B did not have evidence of training in recognizing and responding to resident changes of condition. Caregiver C did not have evidence of training in recognizing and responding to resident changes of condition, preventing and reporting resident abuse, neglect, and misappropriation of resident property; or information regarding assessed needs and individual services for each resident for whom s/he was responsible. Findings include: On 06/13/2023, Surveyor conducted a review of 2 employees to verify compliance with orientation training requirements. Surveyor requested training records from Administrator A for Caregivers B and C. The record for Caregiver B, hired 01/04/2023, did not contain evidence of training in recognizing and responding to resident changes of condition. The record for Caregiver C, hired 03/07/2023, did not contain evidence of training in recognizing and responding to resident changes of condition, preventing and reporting resident abuse, neglect, and misappropriation of resident property; or information regarding assessed needs and individual services for each resident for whom s/he was responsible. On 06/13/2023, at approximately 1:15 p.m., Surveyor interviewed Administrator A.	N 230		

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N 230	Continued From page 2 Administrator A reported that s/he went over resident changes of condition and his/her expectations of staff calling him/her to notify him/her of any changes of condition during each caregiver's orientation. Surveyor asked Administrator A if s/he had any policies or training documents for Surveyor to review that included the change of condition training providing. Administrator A replied that s/he did not and that the training was verbal. Administrator A acknowledged Surveyor's concern that there was no way to verify what the training in change of condition consisted of or that Caregivers B and C had been trained in it. Within the same interview, Administrator A reported that s/he provided Caregiver C with training materials covering preventing and reporting abuse, neglect, and misappropriation at his/her time of hire. Administrator A reported that Caregiver C was expected to return the completed quiz associated with the training as proof of training completion, however, as of May 2023 s/he still had not turned in the quiz. Administrator A reported that because of this, Caregiver C was provided the training materials again during the provider's May 2023 staff meeting. Administrator A reported s/he was still waiting for Caregiver C to turn in the training quiz. Administrator A confirmed Surveyor's concern that there was no way to verify whether Caregiver C completed the training or reviewed the materials provided for preventing and reporting abuse, neglect, and misappropriation. Within the same interview, Administrator A reported that during orientation caregiving staff reviewed resident individual service plans (ISPs) for all the provider's residents and signed off on a form indicating that they had reviewed them.	N 230		

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N 230	Continued From page 3 Administrator A showed an example to Surveyor of Caregiver B having signed off on a form reviewing resident ISPs. Surveyor asked if Caregiver C had signed off on any of the resident ISP review forms. Administrator A reported s/he did not and confirmed s/he had no evidence that Caregiver C completed training in current resident needs and services. Administrator A reported s/he would be following up with Caregiver C to ensure this was completed.	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting	N 243		

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employment.
Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group.
Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 2 of 2 employees reviewed obtained all training as required within 90 days after starting employment.

Caregivers B and C did not have training in recognizing, preventing, managing, and responding to challenging behaviors within 90 days after starting employment.

Findings include:

On 06/13/2023, Surveyor conducted a review of 2 employees to verify compliance with all employee training requirements. Surveyor requested training records from Administrator A for Caregivers B and C.

The record for Caregiver B, hired 01/04/2023, did not contain evidence of training in recognizing, preventing, managing, and responding to

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N 243	Continued From page 5 challenging behaviors. The record for Caregiver C, hired 03/07/2023, did not contain evidence of training in recognizing, preventing, managing, and responding to challenging behaviors. On 06/13/2023, at approximately 1:15 p.m., Surveyor interviewed Administrator A. Administrator A reported s/he thought challenging behaviors training was covered as part of skills training or dementia training that Caregivers B and C would have completed upon their orientation. After reviewing the provider's training materials and comparing it to the challenging behaviors training topics included in the regulation with Surveyor, Administrator A confirmed s/he had no evidence that Caregivers B and C were trained in challenging behaviors or met an exemption for challenging behaviors training.	N 243		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and	N 383		

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participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the preadmission assessment for Resident 1 included all the minimum areas applicable to him/her.

Findings include:

On 06/13/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/22/2022 with diagnoses including Alzheimer's disease. Surveyor reviewed Resident 1's current individual service plan (ISP), which was completed upon his/her admission on 11/22/2022. The ISP indicated that Resident 1 had an activated healthcare power of attorney as well as the following:

- Under the "General Health" section: Safety from falls was one of his/her primary health concerns.

- Under the "Toileting" section: "[Resident 1] is

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usually incontinent of bowel and bladder [s/he] wears depends day and [overnight]. Staff will monitor [Resident 1] closely to ensure that [s/he] is voiding in the bathroom and not in inappropriate areas. This can be a challenge with [Resident 1]."

- Under the "Mental and Emotional Health" section: "[Resident 1] can be a quiet, soft spoken [person] at times. [S/he] will initiate interaction with others at times. [S/he] is usually pleasant to interact with. At other times [s/he] does not always interact appropriately with peers and becomes upset with them when [s/he] feels they are in [his/her] space. [Resident 1] does become agitated at times, primarily during 'sun downing time' ...[Resident 1] is verbal but not always able to accurately communicate what [s/he] needs due to memory impairment ..."

- Under the "Risks" section: "[Resident 1] does occasionally does[sic] show attempts to wander outside the building and is an elopement risk at this time. Staff will ensure that doors are kept alarmed, and that [Resident 1] is encouraged to keep busy with activities.

- Under the "Capacity for Self-Care" section: " ...Balance and fall prevention will be the focus of concern ...[S/he] currently wears hearing aids during the day ...[Resident 1] does wear glasses at this time ..."

- Under the "Social Participation" section, it indicates that Resident 1 is to be encouraged by staff for both active and passive activity participation as well as peer interaction.

Surveyor then reviewed Resident 1's preadmission assessment. The assessment was

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N 383	Continued From page 8 completed by Administrator A and dated 11/09/2023. The preadmission assessment consisted of the following: - Ambulation: Independent with assistive device, fall risk - Personal cares: Moderate stand-by assistance - Toileting: Moderate stand-by assistance - Dressing: Moderate stand-by assistance - Eating: Independent with setup - "What are the most important aspects impacting this decision? Safety." Nothing else was documented as part of the preadmission assessment. On 06/13/2023, at approximately 3:30 p.m., Surveyor interviewed Administrator A. Administrator A acknowledged Surveyor's concern that not all the required assessment areas that would have applied to Resident 1, including information about his/her fall risk, behavior patterns, capacity for self-care, capacity for self-direction, and social participation, appeared to be part of his/her preadmission assessment. Administrator A reported s/he sometimes has difficulties obtaining all relevant information from other facilities that residents come from but acknowledged understanding of the importance of completing a more thorough preadmission assessment.	N 383		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based	N 389		

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on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that Resident 1's individual service plan was updated to reflect changes in his/her condition and needs upon his/her functional decline.

Findings include:

On 06/13/2023, at approximately 9:45 a.m., Surveyor interviewed Associate Administrator D. In discussing an overview of the current residents, Associate Administrator D reported that Resident 1 utilized a sit-to-stand lift for transfers and had at least 1 fall since 03/01/2023.

At approximately 12:00 p.m., Surveyor observed Resident 1 during lunch. Resident 1 was sitting in a Broda chair and was receiving maximum assistance for feeding, with Enrichment Staff E scooping up spoonfuls of food and feeding them to Resident 1. At times, Resident 1 appeared to be teary and was provided verbal encouragement from Enrichment Staff E.

On 06/13/2023, Surveyor reviewed a resident list for emergency evacuation. The list identified Resident 1 and documented that s/he was

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receiving hospice services.

On 06/13/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/22/2022 with diagnoses including Alzheimer's disease. Surveyor reviewed Resident 1's current individual service plan (ISP), which was completed upon his/her admission on 11/22/2022. The ISP indicated the following:

- Under the "General Health" section: Safety from falls was one of his/her primary health concerns.

- Under the "Eating" section: "[Resident 1] will be offered set up assistance, verbal cues, monitoring, and sometimes physical assistance by [provider] staff when needed. [Resident 1] does not need assistance at this time with feeding."

- Under the "Falling" section: "[Resident 1] is semi-independent with [his/her] mobility. [S/he] does use a walker for balance. [His/her] gait and balance will be monitored for decline and this increases [his/her] fall risk. [S/he] is a high falls risk."

There was no information about Resident 1's hospice services or his/her transfer needs, including the use of a sit-to-stand lift.

On 06/13/2023, at approximately 3:30 p.m., Surveyor interviewed Administrator A. Administrator A confirmed that Resident 1 utilizes a Broda chair for mobility (which s/he sometimes can operate him/herself and sometimes requires staff assistance), receives hospice services, and requires feeding assistance for all meals. Administrator A reported that Resident 1's functional decline had occurred for approximately

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N 389	Continued From page 11 the last couple of months. Administrator A confirmed that Resident 1's ISP was not updated to reflect his/her current functioning and needs and reported s/he should update it.	N 389		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure supervision appropriate to Resident 2's needs was provided. Resident 2, who was identified as an elopement risk and made several documented elopement attempts up to and on the day s/he eloped, eloped from the facility on 03/23/2023. Resident 2 was found by members of the community after s/he sustained a fall at a residential construction site approximately 2 blocks away and fractured his/her left humerus. This is a repeat deficiency. See Statement of Deficiency (SOD) LJFI11, dated 07/26/2021. Findings include:	N 426		

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N 426	Continued From page 12 On 06/13/2023, Surveyor conducted a complaint investigation into concerns of the provider's handling of resident elopements. On 06/13/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 03/01/2023 where s/he resided until s/he was hospitalized on 03/23/2023 and subsequently discharged. Resident 2 was admitted with an activated healthcare power of attorney. Within Resident 2's record, Surveyor reviewed and observed the following: 1. Pre-admission assessment, dated 01/04/2023: Wandering and increased confusion indicated as concerns with the comment, "[S/he]'s a mover." 2. "Level of care assessment" document, not dated: Indicated Resident 2 was independent with ambulation. Under the "Behavior Management" section, the following was circled: "Moderately confused, wandering, difficult to redirect." 3. Temporary individual service plan: Nothing was documented about Resident 2's behaviors or assistance in managing them, including wandering. 4. Progress notes throughout Resident 2's admission: - 03/03/2023: "[S/he] did attempt to leave but easily redirected." - 03/05/2023: "In early evening [s/he] packing[sic] up [his/her] things and attempted to leave. Was easily redirected ..." - 03/14/2023: "I spent one on one time with	N 426		

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[Resident 2] today before lunch. It calmed [his/her] agitation to leave to walk to Illinois."

- 03/20/2023: "[Resident 2] was very agitated this afternoon. [S/he] was talking about saying[sic] to get home, wanted to walk to Illinois. [S/he] packed all [his/her] 'things' in a pillowcase. I intercepted [him/her] a couple of times on the way to the front door. I sat one on one with [Resident 2] 'waiting for the bus' with [him/her] this seemed to calm [him/her].

5. Incident report, dated 03/23/2023, with the following documented: "Resident eloped during meal time. DoorDash and family was ringing doorbell and resident made the choice at that moment to go out the other door, which there I seen[sic] resident wasn't near me anymore."

6. Elopement report, dated 03/23/2023 and signed by Caregiver F, with the following documented as occurring at 6:00 p.m.: "Resident elopped[sic] out of the building. As I seen[sic] resident not in eyesight I immediately began looking for resident. I search[sic] the building then we knew resident had elopped[sic]. Resident was active all day with trying to leave building. That's where I did all the proper [illegible] that I know." The report documented that the door alarm did not sound and that Resident 2 eloped from the "2nd door on to[sic] side." The report also documented that Resident 2 "was found bout[sic] 7 feet from build[sic]," and that s/he "was taken to Emergency Room to be checked out due to Residents[sic] fall ...Resident was trying to elope all through the day."

7. Police report, dated 03/27/2023: "On Thursday, 03/23/2023, at approximately 5:45pm, I was dispatched to [address approximately 0.5 miles

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012266	A. BUILDING: _____ B. WING _____	C 06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD LIVING INC	1040 QUINN DRIVE WAUNAKEE, WI 53597

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 426	Continued From page 14	N 426		

away from the CBRF] for [Resident 2] that fell in front of the residence. While getting [Resident 2] out of a vehicle, [s/he] passed out. We assisted [emergency medical services company] with no further incident and [Resident 2] was transported to [hospital]. [Resident 2]'s information was later learned from Homestead Living staff as [Resident 2] was reported as missing.

8. Second police report, dated 03/27/2023: "On Thursday, 03/23/2023, at approximately 6:35pm, I was dispatched to the Homestead Living Residential Care ...for a report of a missing person. The reporting party stated that [Resident 2] was missing as of 6:00pm. The case is related to the prior [emergency medical services] call ...and the staff was made aware [Resident 2]'s whereabouts ..."

On 06/13/2023, at approximately 1:40 p.m., Surveyor interviewed Administrator A. Administrator A reported s/he was hospitalized nearly the whole time Resident 2 had lived with the provider, including during his/her elopement on 03/23/2023, and so s/he had limited information to provide other than what was already in Resident 2's record. Administrator A reported that there were 2 main front doors, both armed, and when one was de-activated, both were deactivated; however, this mechanism fault was not discovered until Resident 2's elopement. Administrator A reported the provider was having a company come out later in the week to address this. When asked for clarifying information about Resident 2's elopement incident, Administrator A reported that 2 other staff working at that time, around 6:00 p.m., were assisting another resident and that Caregiver F had unarmed the door to let DoorDash and another resident's family member in. Administrator A reported that it is thought that

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N 426	Continued From page 15 during this time, while the doors were unarmed, that Resident 2 had left the facility. Administrator A reported that it is presumed Resident 2 left out the other front door but that it was possible s/he left out either of the facility's side doors. Administrator A confirmed Surveyor's observation that Resident 2 posed an elopement risk, given the progress notes of his/her documented previous elopement attempts and Caregiver F's report that on the day s/he eloped that s/he had been "trying to elope all through the day." Administrator A confirmed Surveyor's observation that it was not clear based on Resident 2's record what supervision staff were providing to manage Resident 2's elopement behaviors up to and including on 03/23/2023. Administrator A reported s/he also didn't know what staff were doing on 03/23/2023 to help manage Resident 2's behaviors or what level of supervision they were providing but agreed with Surveyor that it didn't seem sufficient to Resident 2's needs given s/he eloped that evening. On 06/20/2023, Surveyor reviewed outside medical records provided for Resident 2. The record for his/her emergency admission on 03/23/2023 documented that Resident 2 appeared to trip and fall while at a residential construction site, which was witnessed by construction workers. Resident 2 was then transported to the emergency department where s/he was diagnosed with a moderately displaced left humeral fracture.	N 426		